PY/2021

Date Application Completed_____ Date of Enrollment_____

Child's Application for Enrollment

To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually

CHILD INFORMATION:

Date of Birth: _____ Center Choice(s):_____

Full Name:_____ _____ _____ _____

First Middle Last Gender

Child's Physical Address:_____

Ethnicity: Black ☐ White ☐ Asian ☐ Hispanic ☐ Other ☐ _____

Insurance: Medicaid # _____ Private Insurance # _____ No Insurance ☐

FAMILY INFORMATION:

Child lives with: Mother ☐ Father ☐ Other ☐

Are either of the parents or legal guardians a member of the armed forces or a veteran: Yes ☐ No ☐

Is English spoken in the home? We speak fluent English ☐ Some English ☐ Other language spoken _____

Father/Guardian's Name_____ Ethnicity:_____ DOB:_____

Address (if different from child's)_____ Zip Code _____

Work Phone_____ Cell Phone_____ Home Phone_____

Education: Highest grade completed: _____ GED ☐ High Sch. ☐ Some College ☐ College ☐

Employment: Full Time ☐ Part Time ☐ Unemployed ☐ Enrolled in school ☐

Father's Email: _____

Mother/Guardian's Name_____ Ethnicity:_____ DOB:_____

Address (if different from child's)_____ Zip Code _____

Work Phone_____ Cell Phone_____ Home Phone_____

Education: Highest grade completed: _____ GED ☐ High Sch. ☐ Some College ☐ College ☐

Employment: Full Time ☐ Part Time ☐ Unemployed ☐ Enrolled in school ☐

Mother's Email: _____

Others in Home <u>Dependent</u> on Parent/Guardian Income	Birthdate	Gender	Ethnicity

What elementary school will your child attend: _____ ☐ I am unsure

Is child in child care: Y ☐ N ☐ If yes, Where_____ Daycare voucher: Y ☐ N ☐

Has your child been diagnosed with any kind of special developmental needs or delays? Yes ☐ No ☐

If so, which agency or school made the diagnosis: _____

Does your child have an Individualized Education Plan (IEP) or an Individualized Family Service Plan (IFSP)? Yes ☐ No ☐

If yes, what school system or agency is it through: _____

Does your child receive any kind of specialized support services? (Please check all that apply)

Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ ABA Therapy ☐

Home Visits From Early Intervention ☐ Social Skills Program ☐ Other ☐ explain _____

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals. All applicants must have at least two alternate contacts as required by NC DHHS updated guidance.

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional.

All Lines Must Be Completed or N/A for Non-Applicable added to all Questions Below:

1.) List any allergies and the symptoms and type of response required for allergic reactions.

_____

_____

2.) List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns

_____

_____

3.) List any particular fears or unique behavior characteristics the child has _____

_____

4.) List any types of medication taken for health care needs _____

5.) Share any other information that has a direct bearing on assuring safe medical treatment for your child _____

_____

Nutritional Needs:

Does child have special dietary needs: Y ☐ N ☐ if yes, please explain _____

Child needs special milk: Y ☐ N ☐ if yes, please list _____

EMERGENCY MEDICAL CARE INFORMATION:

Name of child's doctor _____ Office Phone _____

Name of child's dentist _____ Office Phone _____

Hospital preference _____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian_____Date_____

I certify that all of the information included in this application is true to the best of my knowledge. I understand I am responsible for calling I-CARE, Inc. (704-873-2858 or 828-464-1108) with any changes to information on this application (phone number, address, income, etc.). I give my permission for the information on this application and any other documentation that was submitted with this application to be shared with Family Service Worker, Family Service Manager, Classroom Staff, Division of Child Development and Early Education, or others as necessary to verify accuracy and provide appropriate services for my child. I understand that knowingly providing inaccurate information will result in this application being rejected. I understand that the completion of this application and the submission of required / requested documents *does not* guarantee enrollment of my child(ren).

Signature of Parent/Guardian _____ Date _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator/Designee:_____Date_____

Student Residency Form

_____ _____
Child's Name Date of Birth

The answers to the following questions will help to determine what services the child will qualify for under the McKinney-Vento Act.

1. Is this child's home temporary? ☐ Yes ☐ no

2. Is this a temporary housing arrangement due to loss of housing or financial hardship? ☐ Yes ☐ no

3. Is this a temporary living arrangement due to a natural disaster or fire? ☐ Yes ☐ no

4. Is this a temporary living arrangement due to domestic violence? ☐ Yes ☐ no

5. Is this child living in a car, park, abandoned building, bus or train station? ☐ Yes ☐ no

6. Does this child live with someone other than his parents? ☐ Yes ☐ no

7. Where does this child currently live? (Check the appropriate box)

☐ In a motel, transitional housing ☐ In a shelter, group home ☐ With more than one family in a house or apartment

☐ Moving from one place to another ☐ Other Explain: _____

I-CARE Inc. has my consent to contact a third party to verify my residency if I, as the parent, feel my child may qualify for services under the McKinney-Vento Act.

Name: _____ Relationship to Family: _____

Telephone number: _____

Parent Signature: _____ Date: _____

Office use only

To the best of your knowledge, is this child classified as homeless under the McKinney-Vento Act? ☐ Yes ☐ No
Staff Name: _____ Staff Signature: _____ Date: _____
☐ Verified student residency through intake interview.
☐ Verified student residency through form & third party.